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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NATHAN DAVID GIESBRECHT** **10582 French Meadows Way** **Reno, NV 89521** **Registered Nurse License No. 613855** Respondent.	Case No. 2012-16 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 14, 2003, the Board of Registered Nursing issued Registered Nurse License Number 613855 to Nathan David Giesbrecht (Respondent). The Registered Nurse License expired on October 31, 2008, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

8. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

9. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

10. "Morphine Sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and is a dangerous drug pursuant to Code section 4022. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration.

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Out of State Discipline)
(Bus. & Prof. Code § 2761, subd. (a)(4))

12. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about May 17, 2007, in a disciplinary action before the State of Montana Board of Nursing, Department of Labor and Industry (Montana Board), the Montana Board entered a Final Order of Default (Final Order) placing Respondent's license on probation for two years. The Final Order required Respondent to: (1) complete the following courses: "Ethics of Nursing Practice," "Professional Accountability and Legal Liability for Nurses," "Documentation: A Critical Aspect of Client Care," "Sharpening Critical Thinking

Skills," and "Medication Errors: Detection Prevention"; (2) review and obey all laws and rules pertaining to the conduct of nurses in Montana; (3) thoroughly read and review all nursing policies, procedures, and rules in place at Respondent's place of employment, as well as any other information which Respondent's immediate supervisor thinks would be helpful to Respondent; (4) notify the Montana Board within 10 days of any change in employment, home address, or name; (5) report to the Montana Board at quarterly intervals regarding his progress at his place of employment; (6) ensure that his immediate on-site supervisor presents quarterly reviews of Respondent's progress to the Montana Board; and (7) immediately provide a copy of the Notice and Stipulation to his supervisor(s) at all of the places where he is employed or becomes employed during the period of probation.

13. The Montana Board entered the above Final Order based upon the fact that on or about February 5, 2007, the Montana Board mailed by certified mail a copy of the Notice of Proposed Board Action (Notice) to Respondent's last known address. The U.S. Postal Service subsequently returned the Notice marked "Return to Sender/Moved/Left No Address/Unable to Forward." The Montana Board subsequently effected service of the Notice through a Summons for Publication on March 22, 2007, March 29, 2007, and April 5, 2007, in the Independent Record, a daily newspaper of general circulation published in Helena, Montana, and in the Daily Inter Lake, a daily newspaper of general circulation published in Kalispell, Montana. No request for hearing was received by the Montana Board. Upon receipt of Department counsel's May 1, 2007 Request for Entry of Default, the Montana Board issued an Order Granting Entry of Default on or about May 17, 2007. The Montana Board entered the above Final Order on or about May 17, 2007. The factual assertions and conclusions contained in the Notice were adopted by and fully incorporated into the Montana Board's Final Order as findings of fact and conclusions of law. The factual assertions and conclusions contained in the February 5, 2007 Notice are set forth below.

14. On or about December 12, 2005, the Montana Board received a Complaint from Riki Handstede, R.N., the Emergency Department (ED) supervisor at Montana Hospital. The Complaint alleged that Respondent was oriented in the ED and was informed of the facility's

policies on narcotics keys, wasting of narcotics, and documentation on the Narcotic Control Sheet. According to the Complaint, on a date prior to December 12, 2005, Respondent diluted Morphine Sulfate with Normal Saline in a 10 cubic centimeter syringe and administered it to a patient who was brought into the emergency room by ambulance. Respondent retrieved the medication from the narcotic cabinet and mixed it without a witness. Respondent documented on the patient's Medication Administration Record (MAR) that he administered 2 milligrams of Morphine at 10:05 p.m. Respondent documented on the patient's MAR that he administered another 2 milligrams of Morphine at 10:15 p.m. The physician's order was only for 2 milligrams of Morphine and the physician did not recall ordering more Morphine for that particular patient. The Emergency Department Treatment Record (EDTR) contained no documentation by Respondent regarding the Morphine administration to the patient. According the Complaint, the second dose of Morphine was not signed out on the Pharmacy Control Record and the partial dose of Morphine was not destroyed in the presence of a witness. There was no documentation about the Morphine being wasted by Respondent and the ED nurse was never asked to witness the wasting of any Morphine. Finally, the Complaint alleged that Respondent left the narcotics keys sitting on the floor.

15. On or about October 31, 2005, the Montana Board received Respondent's response to the above Complaint. In his response, Respondent denied diverting drugs, admitted that the narcotics keys were on the counter in front of him, and admitted that he was guilty of a discrepancy with the hospital's policy on narcotic wastage and signing.

16. On or about December 2, 2005, the Montana Board's Screening Panel assigned an investigator to Respondent's case. The investigation report, dated October 25, 2006, revealed that on the date of the events referenced above, nobody at the hospital witnessed Respondent check out, draw up, or dilute the Morphine Sulfate. The MAR for the above-referenced patient reflected that Respondent administered 2 milligrams of Morphine Sulfate Intravenous pyelogram (IVP) at 11:05 p.m., and 2 milligrams of Morphine Sulfate IVP at 11:15 p.m. The physician's order for that patient specified administration of 2 milligrams of Morphine Sulfate. The EDTR revealed that Respondent did not enter follow-up vital signs into the record after he administered the

Morphine Sulfate. There was no documentation in the EDTR that Morphine Sulfate was given to the patient. Respondent explained to the investigator that diluting the Morphine Sulfate with Normal Saline is a technique that he sometimes uses and which he was taught in nursing school as a way to alleviate the uncomfortable burning sensation that patients sometimes experience with when administered Morphine Sulfate. Respondent further stated that this practice is not unusual in nursing, particularly in Canada. Riki Handstede, R.N., told the investigator that she is totally unfamiliar with the practice of administering Morphine Sulfate that has been diluted with Normal Saline. Respondent admitted that on the date of the events giving rise to the Complaint, he was distracted by a tense work situation with his supervisor when he signed out, drew up, diluted, and wasted the Morphine Sulfate without a witness. Respondent claimed that due to his distraction, he forgot to follow policy and procedure regarding narcotics administration, which he understood was a violation of the hospital's policy and procedure. Respondent also admitted that he understood that the narcotics keys should have been on his person, however according to Respondent, the keys were lying on the counter at the nurse's station and were within inches of his reach and never out of his sight. The Montana Board concluded that Respondent committed unprofessional conduct.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 613855, issued to Nathan David Giesbrecht;

2. Ordering Nathan David Giesbrecht to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 12, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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